A Rapid Field Appraisal of Reproductive Health Care Needs and Reproductive Health Services in the Philippines

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February 2001

A Rapid Appraisal of Reproductive Health Care Needs and Reproductive Health Services in the Philippines, December 2000. This study was funded by the **U.S. Agency for International Development (USAID)** under the terms of Cooperative Agreement number HRN-A-00-98-00012-00 and Subproject number 5801 13035 455. The opinions expressed herein are those of the authors and do not necessarily reflect the views of USAID.

SUMMARY

The Population Council, upon the request of USAID/Manila, conducted a rapid field appraisal of reproductive health care needs and available reproductive health services in the Philippines in May-July 2000. The study's immediate objective is to assess the knowledge, attitudes, and perceptions of key stakeholders on issues that affect family planning and reproductive health care services, with the ultimate goal of developing policies that support devolved family planning and reproductive health care programs in the country. Cooperating agencies and other stakeholders have already used the study's findings to create action plans.

Findings on the knowledge component show that there is no common understanding of the term *reproductive health* among the different stakeholders. Generally, knowledge is related to access and utilization of reproductive health services. Men, local officials, and the youth tend to be less knowledgeable about the reproductive health concept. Young unmarried men are more likely to be aware of STI/HIV/AIDS and safe sex issues compared to unmarried women. As expected, health service providers and their women clientele display a far greater understanding and appreciation of reproductive health. Service providers' level of appreciation and knowledge of reproductive health is influenced by their attendance in reproductive health training programs while that of women is influenced by whether or not they have used health services.

Perceptions regarding the issues clustered around the following lines:

a) The delivery of health services in private health facilities is perceived to be generally superior over that of the public sector's in terms of infrastructure, equipment, supplies, and quality of care.

b) In general, health concerns are not seen as priorities of officials in local government. This is compounded by the absence of institutionalized mechanisms to bring local health needs to the attention of local officials.

c) Local officials are seen as sometimes interfering with routine services such that availability of health care supplies and medicines becomes dependent on patronage and political favors.

d) Church or religious influence on family planning and childbearing decisions was perceived as having minimal impact on personal decisions .

The converging attitudes reported by the participants refer to the following:

a) Respondents expressed a negative attitude towards the charging of fees for public health services (expressed mainly by married respondents);

b) Health personnel (*barangay* health workers, nurses, midwives, and doctors) are generally welcomed and appreciated as important sources and communicators of reproductive health information;

c) In terms of family planning decision-making patterns, many married women report that they usually make autonomous decision on this matter; nevertheless, they are open and receptive to the advice and recommendations of relatives and health care providers.

The study is a collaborative effort of USAID/Manila and major government agencies, the Commission on Population, and the Department of Health, and cooperating agencies: AVSC International, De La Salle University, The Futures Group, Johns Hopkins University/Population Communication Services (JHU/PCS), John Snow Inc. Research and Training Institute, Management Sciences for Health, Program for Appropriate Technology in Health, Pearl S. Buck International, FriendlyCare Foundation, Inc., and Population Council, and Local Government Units (LGU) officials and program managers. Each of the agencies developed actions plans for FY 2001-2002 in response to the findings of the rapid field appraisal. An evaluation of actual utilization based on these plans will be undertaken at the end of 2001 as part of FRONTIERS' Intermediate Result 2 activities.

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ABBREVIATIONS

BHS	*Barangay* (village) health station
BHW	*Barangay* health worker
BSPO	*Barangay* service point officer
CA	Cooperating agency
CHO	City health officer
CPO	City population officer
DLSU	De La Salle University
DMPA	Depot medroxy progesterone acetate (injectable contraceptive)
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FCFI	Friendly Care Foundation Inc.
FGD	Focus group discussion
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
IEC	Information, education, and communication
IUD	Intrauterine device
JHU	Johns Hopkins University
JSI	John Snow Inc.
LCE	Local chief executive
LGU	Local government unit
MCH	Maternal and child health
MSH	Management Sciences for Health
NGO	Non-government organization
NHIP	National Health Insurance Program
OPHN	Office of Population, Health and Nutrition
PATH	Program for Appropriate Technology in Health
PHIC	Philippine Health Insurance Corporation
PHO	Provincial health officer
PPO	Provincial population officer
POPCOM	Commission on Population
PSBI	Pearl S. Buck International
RH	Reproductive health
RHU	Rural health unit
RTI	Reproductive tract infection
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TFG	The Futures Group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UTI	Urinary tract infection

ACKNOWLEDGEMENT

The Population Council appreciates the support of USAID/Manila - Office of Population, Health and Nutrition (OPHN) staff in the conduct of the study "Rapid Field Appraisal of Reproductive Health Care Needs and Available Reproductive Health Services in the Philippines." The study would not have been possible without the support of Mr. Leonardo Dayao of OPHN who co-facilitated the planning workshops and headed the study team for the Mindanao areas. Mr. Ephraim Despabiladeras and Ms. Nilda Perez, also of OPHN, ably served as team leaders of the two areas in Visayas: Iloilo and Tacloban.

The cooperation and inputs of the following cooperating agencies are likewise acknowledged: AVSC International, De La Salle University, Department of Health, FriendlyCare Foundation, Inc., Johns Hopkins University/Population Communication Services, John Snow Inc. Research and Training Institute, Management Sciences for Health, Program for Appropriate Technology in Health, Pearl S. Buck International, and The Futures Group.

Executive Director Tomas Osias and Deputy Executive Director Mia Ventura mobilized the Commission on Population (POPCOM) regional offices to assist the study teams assigned in their regions. Mr. Nolito Quilang, Program Management Officer of POPCOM, was actively involved with the Mindanao team and provided valuable inputs during the planning stage of this activity. We likewise thank all the regional POPCOM staff for arranging the focus group discussions and interviews as well as the dissemination activities in their areas. Ms. Lolita Layser, POPCOM Regional Director for Region 4, deserves special mention for her heroic efforts to brave the floods with her teammates in Pangasinan in the midst of typhoon *Senyang* in order to complete the interviews. Appreciation is also due to all local government officials who extended their hospitality and cooperation to the study teams.

Finally, the study teams wish to express their gratitude to the numerous men and women in the different communities, service providers, program managers, and local government officials who gave their time and expressed their views on the many sensitive issues raised in the study.

INTRODUCTION

This report presents the findings from a rapid field appraisal of men and women's reproductive health care needs and the range of reproductive health services available in the Philippines. These findings are based on fieldwork conducted in May – July 2000 in 15 locations throughout the Philippines. The areas represent both rural and urban areas spread across the country's major island groups. The distinctive feature of this study lies in the collaboration of the major government agencies, the Commission on Population (POPCOM) and the Department of Health (DOH), cooperating agencies (CAs), and USAID/Manila in planning and undertaking the field work and analysis of data. This partnership arrangement served to strengthen the utilization of findings. The rapid feed-back of results also allowed the study team to disseminate the major findings to national and local stakeholders who, in turn, developed action plans to address their specific reproductive health concerns.

OBJECTIVES AND RESEARCH QUESTIONS

The overall goal of the rapid field appraisal is to develop health care policies that support the implementation of quality family planning and reproductive health care programs within devolved governance. The immediate objective is to ascertain the major stakeholders' knowledge, attitudes, and perceptions about reproductive health care services in the country.

The major stakeholders for this study are the following:

- local decision makers: mayors, vice mayors, members of health councils;
- local program managers – city health and population officers, local heads of POPCOM and DOH;
- service providers: public and private sectors, physicians, nurses, midwives, and outreach workers;
- the community – men and women, married and unmarried;
- national decision-makers from the two major government agencies directly involved in population and health related concerns, namely POPCOM and DOH; and
- USAID/Manila along with its core of cooperating agencies that help to support the country's implementation of the family planning/reproductive health programs.

The devolution of national government functions to local governments through the Local Government Code of 1991 created numerous challenges for reproductive health programs throughout the country as many local government units (LGUs) still lack the resources and managerial expertise to implement local health care programs. In fact, the National Demographic Survey of 1998 revealed that health care indicators registered some decline since health services have been devolved to LGUs.

As USAID began to redirect its program to provide major support for private sector initiatives to expand the delivery of family planning and other reproductive health services, the Office of Population Health and Nutrition (OPHN), USAID/Manila requested Population Council to lead a nationwide rapid field appraisal initiative in order to better understand the dynamics of local health policymaking, program management, and delivery of quality family planning and reproductive health care services. The present study is a direct response to USAID/Manila's concerns in this regard.

The Population Council, in coordination with USAID/Manila, subsequently held three planning workshops intended to discuss the rapid field appraisal plans with the major stakeholders located in the Manila area. First, an orientation on the nature of the rapid field appraisal and techniques of doing a qualitative study was held during the meetings of the study team. Two resource persons were invited to speak on these topics: a former consultant of USAID/Bangladesh who provided the technical assistance for a rapid field appraisal in Bangladesh but is currently working in the Philippines, and a professor from a local university who specializes in qualitative methodology. The next activity consisted of a workshop to identify key research questions. A workshop was then held to draft the guide questions and finalize the schedule for data collection. The following research questions were developed by the study teams for the rapid field appraisal activity:

1. How do different groups (stakeholders) in Philippine communities understand the term "reproductive health" and how do they define a reproductive health care program?

2. What kind of reproductive health care services are available in local health facilities and how do local groups assess the quality of health service delivery at public and private facilities?

3. What additional family planning and reproductive health care services, or improvements in existing services, do people want in their local health facilities?

4. How much support and/or opposition exists at local levels for health programs, specifically for family planning and reproductive health care services delivery?

5. Are clients willing and able to pay for reproductive health care services?

6. What or who are the common sources of family planning and reproductive health care information in communities? Are current sources adequate? What additional reproductive health information do communities want and need?

7. What are the main factors that influence decision-making processes on family planning and reproductive health care matters for clients, health program personnel, service provider, and local authority perspectives?

METHODOLOGY

The study features the active participation of policymakers, program managers, and other CAs in the data collection and analysis. FRONTIERS staff in the Philippines and the USAID/Manila OPHN staff managed this study. The rapid field appraisal employed the following qualitative research methods:

- In-depth, unstructured interviews of selected key informants
- Focus group discussions of different categories of respondents: a) married men and women and unmarried women and men between the ages of 18-24 years; b) service providers; c) program managers in public and private facilities; and d) local officials from cities, municipalities, and *barangays*

The study teams collected data from purposively chosen areas in order to provide sufficient variation in socioeconomic and health conditions, and geographical locations. Specifically, the rapid field appraisal was conducted in Metro Manila and in urban and rural areas of Luzon, Visayas, and Mindanao. The study sites chosen included communities/LGUs ranked as high-performing and low-performing in terms of four major health indicators (fully immunized child, contraceptive prevalence rate, Vitamin A coverage, and tetanus toxoid) according to the 1997 Multi-indicator Cluster Survey.

The partner agencies were divided into research teams (Appendix 1) and assigned to the different locations shown in Table 1.

Table 1. Location of fieldwork sites

MAJOR STUDY AREAS	FIELDWORK SITES
Metro Manila	Muntinlupa City; Quezon City
Luzon	Baguio City; Mangaldan, Pangasinan; San Carlos City, Pangasinan; Caba, La Union; San Fernando, La Union
Visayas	Iloilo City; Passi City; Tacloban City, Leyte; Albuera and Baybay, Ormoc
Mindanao	Davao City; Tagum City, Davao del Norte; Carmen, Davao del Norte; Bongao, Tawi-tawi

Focus group discussions (FGDs) were conducted among each category of respondents. Key informant interviews were conducted with city health officers, population officers, hospital administrators, and local officials who are either directly or indirectly responsible for health care policy (e.g., mayors and vice-mayors, *barangay* captains, local councilors, and members of local health and development councils).

Table 2 shows the distribution of study respondents by geographic area.

Table 2. Distribution of respondents by geographic area

AREA	RESPONDENTS				TOTAL
	Men and women (Married and unmarried)[a]	Service providers	Program managers	LGU officials	
Metro Manila	59	43	6	14	122
Luzon	146	91	8	37	**282**
Visayas	150	118	15	44	**327**
Mindanao	148	132	4	12	**296**
TOTAL	**503**	**384**	**33**	**107**	**1,027**

[a] There are 262 married and 241 unmarried respondents.

A total of 1,027 people participated in FGDs or key informant interviews throughout the 15 areas visited by the study teams. Of these, 262 were married women or men, 241 young male or female adults, 384 service providers (doctors, nurses, midwives, health workers), 33 program managers, and 107 local officials (mayors, vice mayors, *barangay* captains, and members of *barangay*, municipal or city councils).

Table 3 shows the number of focus group discussions held for the different categories of participants in each major geographical area.

Table 3. Total number of focus group discussions held by category and geographic area

Geographical Areas	Married women	Married men	Unmarried women	Unmarried men	Physician CHO/ MHO	Nurses	Midwives	BHWs/ BSPOs	Barangay Captains[a]	**Total**
Northern Luzon	5	5	5	5	3	2	4	5	2	**36**
Metro Manila	2	1	2	2	2	2	1	1	1	**14**
Visayas	4	4	4	4	3	4	2	3	3	**31**
Mindanao	4	3	4	4	4	0	4	4	0	**27**
Total	**15**	**13**	**15**	**15**	**12**	**8**	**11**	**13**	**6**	**108**

[a] Some *barangay* captains were not interviewed individually. They were included in the FGDs in some areas (Quezon City, Baguio City, Caba, La Union, Passi and Iloilo cities, and Ormoc).

A total of 94 program managers and local officials were interviewed. The distribution is shown in Table 4.

Table 4. Total number of key informants by type and geographic area

Respondent	Northern Luzon	Metro Manila	Visayas	Mindanao	Total
Program Managers	8	6	15	4	33
CPO	1	0	2	1	4
PPO	0	0	2	1	3
CHO	3	0	3	0	6
MHO	2	0	0	2	4
Hospital Director/Private Doctor	2	6	8	0	16
Local Officials	24	7	18	12	61
Mayor	4	1	4	3	12
Vice Mayor	2	1	3	0	6
SB/SP on Health	2	1	1	2	6
Barangay Captains[a]	14	4	8	3	29
Councilors	2	0	0	2	4
Governor/ Mayor rep	0	0	2	2	4
Total	**32**	**13**	**33**	**16**	**94**

FIELDWORK

Four research teams (a total of 27 researchers) conducted the fieldwork from May 28 to July 7, 2000. FRONTIERS project staff coordinated the fieldwork and solicited the assistance of the regional offices of POPCOM and DOH in contacting potential participants of FGDs and arranging interviews with key informants. *Barangay* service point officers and *barangay* health workers provided additional assistance in scheduling and arranging the venues for FGDs and key informant interviews.

The strategy of working with the POPCOM network in the local areas was most useful in arranging FGDs and interviews. However, since in most cases the local health providers of the city or municipal government contacted participants in the FGDs, it is likely that the results are biased towards representing the viewpoints of people who may have had some experience with the local health system.

Since the nature of a rapid field appraisal calls for a highly participatory process of data collection and analysis, close consultations with all the participating agencies were maintained throughout this activity. Frequent meetings were held to achieve a general consensus on the key steps in data collection, data analysis, and report writing. This process is described in Appendix 2.

FINDINGS

The principal findings together with some recommendations are presented in this section according to the seven major research questions that guided the study.

1. Stakeholders' understanding/definition of the term "reproductive health"

> "For me, reproductive health refers to everything that has to do with sex."
> - An unmarried male, FGD
>
> "Maybe it refers to our bodies, like when a woman starts to have menstruation."
> - A young unmarried woman, FGD

The findings reveal that reproductive health takes on different meanings or associations for different categories of respondents. The more popularly known aspects of reproductive health cluster around the following: family planning, along with mention of different contraceptive methods; safe sex, sexuality, body awareness, and sex organs; pregnancy and childbirth, including practices such as prenatal and postpartum visits; health of mother and children, with mention of immunization, nutrition; general health, family health, and health of women and men.

Each group tends to emphasize a particular dimension of reproductive health**.** Government officials and men in general tended to have less familiarity with the concept. A group of men from a certain locality refused to participate in a planned FGD because they said they knew "nothing of reproductive health." Analysis of the FGD results shows

that women are more likely to mention more components of reproductive health as compared to men. However, they are also less likely to mention STI/HIV in their responses, while men tend to zero in on this aspect of reproductive health. This pattern is especially true among FGDs of young unmarried respondents. Sexually transmitted diseases and HIV/AIDS-related concerns are cited in five out of 15 FGDs of young men, compared to only two among FGDs of young women. Men's FGDs contain discussions about safe sex, sexuality, body awareness, and sexually transmitted diseases. However, less than half of FGDs of young women mentioned these issues. When asked, women tend to focus their responses more on family planning, maternal and child health, or family health in general.

Another finding that is worth noting is the rather low awareness of reproductive health among local officials. The majority were likely to associate reproductive health with "general health," "family health," or the health of their constituencies. Many mentioned that it is a "health program" emanating from DOH. A city mayor claims it is about "controlling population growth through responsible parenthood" in order to help promote development and reduce poverty.

The following quotations represent typical responses to the question "What comes to mind when you hear the word reproductive health?"

> *I think reproductive health refers to birth control* (Married man, FGD)
>
> *This refers to anything that women feel about their bodies, especially about giving birth. But maybe family planning is included there, the thing that they call IUD. Because you know, reproduction means "to give birth*". (Married woman, FGD)
>
> *Reproductive health is about family planning - there are many - NFP, condom, ligation - pregnancy and childbirth, prenatal, and immunization. This pertains to our (women's) good health*. (Married woman, FGD)
>
> *That is a good thing. I think it would be even better if it can be implemented* (City *barangay* captain, in-depth interview).

On the other hand, program managers and service providers have the highest and more comprehensive understanding of reproductive health. Noticeably, those who have recently attended the reproductive health training sessions conducted by the DOH have more sophisticated knowledge. They mention the so-called "life cycle" or the "10 elements" of reproductive health, and use such expressions as "from womb to tomb". They are aware that reproductive health cover specialized services, such as the treatment of RTIs/UTIs, STIs, and HIV/AIDS, infertility, and menopause. Service providers mentioned other aspects of reproductive health that were hardly ever elicited from other groups, such as gender, domestic violence, and the focus of family planning program particularly on women of reproductive age. This finding demonstrates the effects of good reproductive health training, such as that conducted by DOH. Married women who have availed of services in the health centers tend to have more factual knowledge about reproductive health and can cite more concrete reproductive health services available in the community.

In summary, the findings on this topic uncover certain gaps and deficiencies that need to be addressed. The rather low awareness about sexually transmitted diseases and safe sex among young women, if it continues to remain at this level, does not bode well with prospects for curbing the spread of STIs in this country. Likewise, the low awareness and understanding of reproductive health by local government officials, deserve particular mention because local officials determine to a great extent the availability of health services through allocation of financial resources. Furthermore, the finding that respondents' exposure to reproductive health-related training, IEC programs, and reproductive health services has a high correlation to their level of reproductive health awareness, points to the need to set up regular training programs for service providers.

Recommendation

It appears that the low level of reproductive health awareness can be ultimately traced to the absence of a decisive and clear national policy on reproductive health. Therefore, a clearer health policy that reflects the paradigm shift towards client-oriented service delivery needs to be defined and effectively implemented An important thrust of this policy should be consciousness-raising, adequate information, comprehensive understanding, and formation of positive attitudes on the part of the population with respect to reproductive health.

2. Availability and quality of reproductive health care services: The public and private health care system

The RFA questions for this section were designed to elicit the following information:

- Types of health (specially reproductive health) services that are available in public and private health facilities at the local level;
- Utilization of these services; and
- Respondents' assessment of the quality of health care services in public and private health facilities.

The services frequently mentioned by the four categories of respondents are:

- family planning (provision of methods and counseling);
- general consultations; and
- maternal and child health-related services.

Data in Table 5 show that the three services – family planning, general consultations, and MCH-related services – were mentioned in 82 FGDs and interviews. As it was assumed that service providers and program managers are already knowledgeable about the services they offer, this question was asked only of married and unmarried respondents and local officials.

Other services mentioned but which are not shown in the table as listed from the highest frequency with which they were mentioned are the following: STIs/HIV/AIDS

(social hygiene clinics), pregnancy test, and cancer screening (pap smear), dental services and sperm count.

Table 5. Services that were often mentioned, by category of FGD[a]

Services mentioned	**Local Officials** N=67 (FGDs and KIs)	**Married men and women** N=28 (FGDs)	**Unmarried men and women** N=30 (FGDs)
Family planning-related (FP methods, IUD check-up)	9	10	10
General consultations (e.g., cough, wound)	6	11	11
MCH-related (e.g., immunization, prenatal visits)	–	13	10

[a] Frequencies shown are those that came up five times and above in each category of FGDs.

It appears that married women with children and who have used the public health services are able to name a wider range of health services compared to other population groups (except service providers and program managers). They were also able to cite specific family planning services (e.g., tubal ligation, IUD check-up), MCH services (e.g., immunization, nutrition, mothers' classes), and higher-level reproductive health services (e.g., pap smear tests, training-seminars, and IEC on STDs, sexuality, and gender awareness).

When married women's responses were compared to those of married men and the youth, it was clear that the latter have limited knowledge of locally available reproductive health services. Discussions show that men and young people rarely visit health facilities except in times of emergency and for curative care. Married women claim that their husbands go to the clinics "when they are already serious and cannot work." Many married men thought of health clinics/centers as "places visited by mothers and children." They presumed that family planning and MCH services were available in local health centers whereas unmarried men only cited the provision of general health services (e.g., consultations, medical and dental care) or on-going health

campaigns (e.g., clean and green campaign, malaria and TB control, anti-rabies drive). Except for general consultations, there is hardly any service in the health center that addresses men's health. Even condoms are distributed to women clients because "husbands do not come to the clinic for condom supplies" as one midwife claimed.

Unmarried men and women are also poorly informed about local health services except for those who had exposure to adolescent and reproductive health programs, and youth centers. Many of these, however, are girls. Some of them go to the centers for reasons other than for consultation such as "accompanying a friend or visiting a relative who is a personnel in the health center." Two young girls, for instance, cited visiting a relative working in the clinic. Another girl said she attended a peer educator program, and the lecture was held at the health center. It is clear that participants in this FGD hardly ever go to the clinic for personal health-related reasons.

Since *barangay* captains and local officials are mostly male, gender may partly explain the fact that they have limited knowledge of the specific health and reproductive health services available in their localities. They also tended to have a more general view of health services in their areas, mentioning as reproductive health those services as free consultations and medicines, dental services, environmental sanitation campaigns along with family planning, and to a certain extent, MCH services.

In summary, the responses indicate that some RH services are generally available in local public health facilities and that their existence is generally well known to the community. Those who actually avail of these services, however, are mostly married women and their children. Men and young people are virtual strangers to these services. The most common services at the local level were family planning, basic consultations and MCH services.

Recommendation

The RFA results provided some useful information on the clear need for a program aimed at greater involvement of men in health care. This may not be a simple task to accomplish as men may self-select themselves out of health care responsibilities. Furthermore, the current nature of RH services tends to marginalize or alienate men as MCH and FP programs offer services almost exclusively for women and children while

many reproductive health seminars and campaigns portray men as the oppressors or villains in marriages and partnerships. Providers of reproductive health services generally look at men primarily in their roles as husbands or partners of women and not as individuals in their own right (the way that women are treated in RH).

There is a need, therefore, for health programs to re-examine their assumptions about men's roles in health and reproductive health care. Innovative ideas and programs are needed to mobilize male involvement in large numbers. Such programs could start by identifying where men could generally be recruited in large numbers. Men's views of their health and the services that would best meet their health problems need to be studied further. Furthermore, other services that relate to men's needs may be provided such as infertility services, prostate cancer screening, and similar men-directed services.

2a. Public vs. private health care system

When asked to assess the health delivery services of public and private facilities, respondent groups almost universally believe that private health facilities are superior to public health facilities. Private clinics are seen to have the following characteristics:

- Better facilities (in a better state of maintenance and repair, cleaner, more spacious) and a more complete, up-to-date range of medical equipment.
- The health personnel of private clinics were also judged as better trained with specializations or more expertise.
- Private clinics were further characterized as having more favorable personnel-to-patient ratios. Private clinics did not have long queues.
- Private clinic staffs were viewed as more accommodating and efficient.
- Private clinics also did not run out of necessary supplies and medicines.
- Patients pay a higher fee for private than public health care services.

Public health facilities, on the other hand, are usually portrayed as the opposite of private facilities.

- Most public health facilities were reported to be in a state of disrepair, lacking basic medical equipment and supplies (e.g., examination tables, blood pressure apparatus, and speculums).

- Public clinics were perceived as understaffed; "patients had to wait longer to be served."

- Personnel of public health centers were not perceived as caring and efficient.

Many respondents attribute the poor facilities and general lack of quality care to the lack of resources in the public health sector. Because of the shortage in personnel (BSPOs and BHWs, for example, serve far more households than the standard ratio of 1 BHW per 25 households), public health workers are perceived as overworked and unable to provide a more "personalized" form of service. However, clients continue to use the public health centers because "consultations and some medicines are free." Respondents indicate that families use the services of public health centers mainly for simple medical conditions and for general FP and MCH care and advice. For more difficult cases, they went to the private facilities.

Respondents reported having observed "*palakasan*" (favoritism) practices in local public health service delivery. They claim that public health officials reserve their supply of free medicines and offer favored treatment to certain persons usually either friends or relatives of service providers. It is not clear whether respondents see a relationship between "*palakasan*" practices and the shortage of resources in public health facilities. Favoritism is not reported among the better-equipped and better-funded private health facilities, though. Table 6 shows the recurring themes (those mentioned five times and above by the category of respondents) referring to the assessment of public and private sector facilities.

Table 6. Recurring themes that emerged in the assessment of private and public health systems elicited from FGDs and interviews, by categories of respondents

Themes	Married respondents N=30 (FGDs)	Unmarried respondents N=30 (FGDs)	Service providers/ Program managers N=44 (FGDs)	Local officials N=4 (FGD) N=36 (KIs)
Lack of personnel and too many patients (public)	–	7	19	–
Lack of supplies, equipment, medicine/facilities (public)	6	–	26	10
Inadequate services/lack IEC/ counseling especially for men and youth/dental/infertility (public)	–	–	40	–
Expensive in private facilities. Public health service is free or affordable/accessible	5	–	–	–
Better quality of care in private facilities; they serve clients faster	–	9	–	–
Unfriendly service providers in public health facilities /there is favoritism	15	13	–	7
Congested; lacks space, long queues in public facilities	12	13	6	–
Lack of time /overloaded, heavy responsibilities in public facilities	–	–	6	–
Lack of training/trained personnel (public)	–	–	8	7
Doctors in public facilities are not “specialists” (they are general practitioners)	–	–	–	7

[a] Blank cells indicate that the themes were either not mentioned or that they were mentioned less than five times.

The main issues that were mentioned in at least three categories of respondents as shown in Table 6 above are (1) lack of supplies, medicines and equipment, (2) lack of

space, congested, long queues, and (3) unfriendly staff or personnel and favoritism, all of which pertain to the basic elements of quality of care.

The overall picture revealed by the findings regarding this issue clearly portrays the general perception of the private health system as far more efficient, better equipped and delivering better quality service than the public health system. The latter's capacity to deliver quality service is perceived as being hampered by lack of resources, overworked personnel, and patronage practices.

Recommendation

In order to improve public health service delivery (including reproductive health), public health centers must be given the necessary assistance to upgrade and build additional facilities, acquire basic equipment as well as regularly update the skills of their personnel in service delivery. Quality of care, particularly focusing on better treatment of clients, stands out as an area that needs to be improved. It is important for program managers to look into the issues raised regarding favoritism or patronage practice in the clinics so that a fair and transparent system may be established.

3. Demand for additional services

When asked the question "What additional reproductive health care related services or improvements in existing services do people want in their local health facilities?" respondents were more likely to cite the need for improving existing public health facilities rather than the need for additional services. Except for the additional demand for support of an effective reproductive health dissemination program, the main findings in the previous section are supported by the analysis of the responses to the question on needed additional services as shown in Table 7.

Table 7. Health services and improvements identified in FGDs and key informant interviews, by category of FGDs and interviews[a]

Demand for additional services or improvements	Married adults	Unmarried Adults	Service providers	Program managers	Local officials[b]
Improved facilities/utilities/ equipment	17	14	24	11	20
More medicines and supplies	9	8	12	–	9
More health personnel	–	5	12	–	7
Improved skills and attitudes of service providers/quality of care / "fair treatment"	17	17	14	9	6
More effective community information dissemination	5	12	9	7	6
Free medicines for the poor	–	–	–	–	6
Increase budget for improvement and maintenance	–	–	5	–	–
Vitamins for malnourished children	–	–	7	–	–
More specialized services such as cancer detection, eye check-up	5	–	–	–	–
Services for the youth – counseling, seminars on STDs/HIV/AIDS	24	–	–	–	–
Incentives/allowances medical benefits for health workers	–	–	5	–	–

[a] Blank cells indicate that either the themes were not mentioned or they were mentioned in less than five FGDs.
[b] Some of the information for this group were derived from in-depth interviews.

All respondent groups agree that local health units are in dire need of resources to improve their facilities and the delivery of public and reproductive health care services. Improvements are needed in physical facilities, medical equipment, supplies and medicines, and in the training of health personnel in the area of quality of care. Quality of

care issues figure clearly in the concerns across sectors and are frequently mentioned among married men and women's groups.

In some areas, existing health facilities remain inadequate to serve the needs of the local population. Respondents cite the need to build new health centers or more satellite clinics in their community. Other sites specifically mention the need for specialized facilities, such as STD clinics and youth centers, for local health programs to respond better to emerging reproductive health needs. Other respondents mentioned that the lack of equipment and supplies for basic medical and laboratory examinations (e.g., pap smear, STDs, X-rays) constrains the ability of local health centers to treat and serve clients promptly.

The shortage of personnel and staff training is a serious problem for many reproductive health care providers. Some program managers and service providers reported that because of limited staff, they could not deliver quality reproductive health services to clients. They do not have the time to provide the necessary counseling for FP clients or to conduct mothers' classes and engage in the additional advocacy and IEC work required for reproductive health care services.

Program managers and service providers also report that their staffs are expected to treat all kinds of health problems and medical conditions and to regularly report statistics on detailed forms required by public health/DOH programs. This heavy workload makes it difficult for them to provide many of the component services of RH or the quality of care expected in these services.

The findings in this area of study bring to a sharper light the state of affairs of the public health system. Rather than demand for additional services, the respondents insisted that what they need are improved and adequate health facilities, skilled, competent and caring health providers and improved health information for the general public.

Recommendations

Because these are longstanding problems cited repeatedly in health program evaluation reports, stronger advocacy is needed to pressure national and local government offices to monitor public health facilities' compliance with the minimum standards (e.g., facility/health personnel-to-population ratios, availability of basic equipment). The

findings also imply that in the near- and medium-term, it may be unrealistic to expect local health facilities to provide a wider range of reproductive health services beyond current FP and MCH services, given that facilities, inadequate trained personnel and lack of equipment are commonly observed to be the weakest points of the health system in local government units. With additional training, personnel and equipment, local public health facilities can improve their services, but they cannot be expected to develop a comprehensive reproductive health care program in the short-term.

The idea of integrating RH services into existing health programs and facilities should be reviewed to see how much integration is organizationally/institutionally feasible within national and local health agencies and given the budget and resource constraints of public health facilities. Some reproductive health component services are best delivered by specialized centers/facilities. A system-wide approach may be needed to provide comprehensive RH services to a given population. An updated directory of the RH services that are available in all the various facilities in a community (public health centers, private clinics, district/city/regional hospitals, social hygiene clinics, youth centers, and others) can help promote awareness and utilization of RH services by the public. Already there are concerns about lack of personnel and training—major components that must be present in order to put in place a truly integrated reproductive health program.

4. Local support for health/reproductive health services

"How much support and/or opposition exists at the local levels for health programs, specifically for family planning and reproductive health care delivery services?" This question was posed to all groups of respondents. For the most part, health program managers and service managers as well as client groups found current LGU support inadequate for successful operation of local health facilities.

Table 8 shows the assessment of this question by each respondent category.

Table 8. Informants' perception regarding local level support to health programs, by category of respondents

Responses	Married respondents	Unmarried respondents	Service providers	Program managers	Local officials
Government officials are supportive of general health projects, but not particularly RH	12	–	–	5	10
Some support but priority are food production, infrastructure, others	8	5	15	–	6
Low support for RH/least priority	–	7	12	7	–

[a] Frequencies shown are those that came up 5 times and above in each category of FGDs.

Local constituents perceive that LGUs and local officials prioritize infrastructure projects and other development concerns (e.g., agricultural production, livelihood and employment, education) over health matters. Local constituents believe that LGUs' interest in health remain only at a generalized level (i.e., the well-being of the population) without much interest in the specifics of health care provision (i.e., reproductive health). A female adolescent complains of the "lack of health care support for young adults like us."

Many health workers and clients doubt the motives of local officials in supporting health services concretely geared toward the undertaking of health-related infrastructure and campaign programs. Local officials, they claimed, favor infrastructure projects (drainage and water systems, health centers, public toilets) because of their politically advantageous high visibility and the opportunities for "kick-backs." As one nurse puts it, "There is support for infrastructure but none for health facilities and equipment." Many people view the LGU projects as merely part of the local patronage system and campaign gimmicks. For instance, a municipal doctor believes that " LGU officials use medical missions only "to get votes."

Many clients report that they are not aware of any specific health initiatives or projects being pursued by their LGUs. Some health program managers, however, believe that given the many demands on government, LGUs and local officials cannot be expected to prioritize health in local development plans and programs.

Because LGUs allocate funds for public health care, client groups, health program managers, and service providers perceive local officials as showing some gestures of support to health services. Local officials, on their part, believe that they are more supportive of public health services than they are usually credited for. This is particularly true in areas where LGU support for health went beyond the usual allocations for medicines, salaries/wages, allowances, and travel expenses of local health workers. For example, one LGU in the Visayas is currently installing a water system for the town and constructing additional health centers. The said LGU also provided health insurance to some indigent households and allowed the public free use of an ambulance. In most other RFA sites, however, LGU support for health is considerably less. A midwife pointed out that the "health budget is small." LGU support is often limited to small budgets for medicines, the wages and allowances of health personnel, or infrastructure projects (drainage system, public toilets, and sanitation) with some health impact.

Respondents from various groups report that they have no opportunities to ask local officials to act on health matters or problems. If such a need arose, they said they would probably approach local officials whom they knew. A few suggested that they probably should ask the *barangay* council to pass a resolution on the matter, or they would discuss and present their concerns to the health officer and other members of their local health units.

> "There is of course the Church. But we know that already. Some priests can be very strict on this (issue) but some are more understanding."
>
> – A married woman, FGD

A point that was probed further is the issue of whether there are individuals or groups in the community that oppose family planning or reproductive health. This is an important question because religion has been cited by many as the reason for the low contraceptive prevalence rate in the country.

In general, respondents did not report active local opposition to reproductive health in their communities. While the Catholic Church is invariably cited as opposing family planning and contraceptives, most respondents claim that religious influence on individual child-bearing/family planning decisions is minimal. However, some respondents thought that a few other religious groups (e.g., Couples for Christ) were becoming more active in opposing family planning and reproductive health, but they were not viewed as a serious threat to their promotion. A sample of these opinions are given in the following quotes from respondents:

> *With me, I use family planning (pill). I am more concerned about the side effects than about thinking whether it is a sin or not. I just don't want another child anymore. I have four children already and it is hard to raise them at this time*. (Married woman, FGD)

> *One time our parish priest talked about that (opposing to family planning) in his homily but nothing happened after that. I thought he will visit our hospital, and I was really uneasy, but he did not.* (Service provider, FGD)

> *I have friends from the Couples for Christ. I found out that they are very outspoken about their opposition to family planning. But I knew about that a long time ago and I have never heard from them since that time*. (Physician, in-depth interview)

In summary, there seems to be an absence of active opposition to FP and RH in the areas that were visited. While this seems encouraging for the program, the role of local governments in health (and particularly reproductive health) cares promotion remains problematic. There is a general perception that the politicians want to play safe and would not want to be singled out by the church, hence many would not go out in the open when it comes to declaring their public support for family planning and other reproductive health related services. Broader and longer-term societal changes are necessary to change the nature of local politics and the actions of local officials/ politicians. Meanwhile, health policymakers and program planners must look for opportunities to increase local government awareness of and support for health care.

Recommendations

Given local officials' preference for infrastructure building and facility improvements, it may be well to challenge them to work on upgrading the state of local public health clinics/centers and ensuring an adequate ratio of health facilities and equipment to household population in their localities. Health advocates could lobby for the inclusion of such criteria (adequacy of health facilities) in local governance awards, such as the *Galing Pook* Award. Another suggestion is to document the experience of local chief executives who won an election by using a health platform as his or her campaign focus. There is still need to demonstrate to politicians that health and population issues are high priority for their constituents and, therefore, can be strong political platform for the voters during election time.

5. Financing health services

In almost all RFA sites the idea of charging fees for public health services is not a popular option. Opposition to fee charging is stronger among clients (especially among married women and men but less so among the young) than among health program managers, service providers, and local officials.

The latter groups recognize the need to charge some fees to sustain local health care services, although this is by no means a consensus, especially among local officials. According to a service provider, charging fees may also "help develop clients' sense of responsibility for their own and their family's health" instead of looking at health care entirely as an entitlement from government. According to another midwife "if there is a participating fee in health care, people will learn to value their health."

In one site, service providers called for the need to set up a system of transparency and accountability in the handling of clinic fees since there is no clear policy up to now how donations from clients should be spent and who is accountable for this money in the clinic.

Married women and men believe that people's taxes are being used to pay the salaries of public health personnel, so people should be able to use the services for free. Actually, some claim that they are not adverse to the idea of charging

> **"**Charging fees is against the essence of public service. If charging of fees is imposed public service will lose its credibility.**"**
>
> –A *barangay* captain, FGD

fees, except that they fear that the demand for service might simply vanish because people cannot pay. One woman said rather sarcastically: "That will surely decongest the clinic, which is what they (clinic personnel) want, anyway." Another young woman said: "When that day comes, I predict that hardly anyone will come back again (to the clinic). However, when they implement this, I just hope that the price is reasonable."

Local officials in most areas also share the opinion that a large number of the clients of public health clinics are too poor to pay for health consultations and visits. One mayor said that he has been contemplating on privatizing health services because government could not afford to provide everything without jeopardizing the number and quality of services. But one vice-mayor fears that if services are not for free, epidemics may occur and will result in bigger problems for the government. Because they had been using these services for free (and receiving some free medicines), program managers and service providers believed that it might be difficult to implement fee for services. The following quotations express the typical sentiments:

> *We do not want to charge fees. That is not a good idea. The people are poor. When they get sick where will they go if they have to pay for health services?* (City mayor, in-depth interview)

> *Where will people get the money to pay for seeing a doctor in the clinic? I am sure there will be fewer people going back to the health center*. (Young unmarried woman, FGD)

> *If fees are charged, they should be minimal and fair.* (Unmarried male, FGD)

> *I'm not against charging fees if the system that is adopted is one in which the indigent are fully subsidized, clients in the second category are made to pay part of the fees, while patients in the third category pay the full amount.* (*Barangay* health worker, FGD)

> *This will make the clinic sustainable. We can roll back the medicines and we can have something there for clients all the time, instead of providing free medicine which is only good for a week or two. The government cannot continue*

> *to provide the medicines for free. But the charges must be just right and affordable to the poor people. You see, if it is free, they will all just rush and get all the medicines in the clinic, and nothing will be left for the others.* (Mayor, in-depth interview)

> *It is nice if there are no fees or charges---but perhaps it is better if people pay for medicines. In my own* barangay, *my medicine would last only for two days. But if there are fees, people will be more prudent about the use of medicine, they will get it only when it is needed. And when they ask you for medicine, you cannot refuse because you are in politics and you want their votes. (Barangay* captain, in-depth interview*)*

Some respondents worry that charging fees would cause public health conditions to deteriorate if fewer mothers, children, and families visit health centers. The also said that child and maternal deaths would rise and family planning use would drop, making it more difficult to pursue local development programs.

The following represent the summary of the issues that were brought out by the RFA respondents on the question of user fees:

- the charges should be judicious and minimal;
- a system/scheme of subsidies should be adopted to ensure that genuinely indigent households will continue to have free access to health care;
- a system of accountability should be devised to ensure transparency in the collection and handling of fees and that these fees are used to support and improve the public health care system; and
- information and education activities should be conducted to prepare the public for the health charges and to explain the rationale for fees.

If ever charges are made, respondents insist that efforts should be made to ensure that the really indigent ones receive free health services. For this reason a good system of identifying the poor is clearly needed. Some local health officials are looking seriously into the Philippine health insurance system and how to utilize this system to solve the dilemma of providing health care access to the lower middle class (Classes C and D) who can hardly afford any health service.

In summary, clients are opposed to charging fees for government health services. Local politicians may even oppose the whole idea, since this will not make them popular with their constituents. However, if fees become necessary, many participants in the FGDs indicate a willingness to pay for health services. The fees plan for health services, however, should be presented to the public ahead of time, and the fees should be "reasonable," or perhaps should be in the form of donations in the case of those who are extremely poor.

Recommendation

The current system of collecting voluntary donations will not be sufficient to sustain clinic operations. Other creative mechanisms to support the operations of local public health centers may need to be employed. In this regard it might be necessary to provide training on developing entrepreneurial spirit among LGU officials and particularly program managers since the latter are often doctors who are not trained to be fundraisers. In order to address the issue of ensuring health care access of the poor, there is a need to expand coverage and benefits of the National Health Insurance Program. More advocacy efforts are needed to increase enrolment of LGUs to the indigence program of the Philippine Health Insurance Corporation (PHIC).

6. Sources of reproductive health information

RFA findings reveal that the sources for RH information vary across respondent groups, and the patterns are not clearly defined. Table 8 shows how responses to this question appear in FGDs by category of respondents.

Table 9. Commonly cited sources of reproductive health information by category of respondents

Sources of RH information	Married adults	Unmarried young adults	Service providers/ Program managers	Local officials
Family (Parents, relatives)	-	10	-	-
Media—Print/radio/TV	15	9	20	9
Health workers/BSPOs/BHWs	14	-	38	20
School (teachers, educators)	-	6	6	-
NGOs	-	-	9	-
Friends/neighbors/peers	9	5	12	-

Mass media are the most common sources of reproductive health information. Respondents recall particular local radio programs on reproductive health and advertisements on television. Several informants also mentioned seeing billboard advertisements as well as other print materials on FP, STDs, AIDS, and other reproductive health topics.

Mass media sources (particularly TV and radio) are the more important sources of RH information for men and youth who are unlikely to visit health centers, attend RH lectures, or engage in personal conversations with relatives and friends on reproductive health.

Family and schools are another common sources of information for youth. Some young respondents mentioned that reproductive health topics (e.g., sex education and population education) are included in the school curriculum and are discussed in some detail in their physical education, health, and music (PEHM) class.

Data from the RFA on community sources of health/reproductive health information pointed to the important role of health personnel/workers (nurses, midwives, and BSPOs/BHWs) as bearers and communicators of RH information. For married women as well as local officials, the local health centers/clinics and health personnel (nurses, midwives and doctors) and direct service providers (BHWs/BSPOs) are very popular sources of RH information, especially for family planning information

Because reproductive health issues are difficult to communicate through fixed mass media advertisements and messages, there is a demand to undertake personal, face-to-face interactions to allow for a better explanation and clarification of RH issues and topics. The data suggest the need to develop IEC materials for specialized client groups such as men and youth and for these to be translated to the vernacular to enhance their use and readership by the public.

Are these sources of reproductive health information sufficient for your needs? The answer to this question is a definite "no." Service providers see the need for basic IEC materials in the clinics to be used for promotion, counseling and meetings, and for education and advocacy for reproductive health that local officials are calling for.

7. Factors influencing reproductive health decision-making

Family planning and reproductive health decisions are made with the influence of partners or service providers, according to married women. Many also said it is pretty much their own decision. The distribution of frequently mentioned decision-makers on matters pertaining to reproductive health across respondent categories is shown in Table 10.

Table 10. Commonly cited decision-makers on matters related to reproductive health, by category of respondents

Decision-maker	Married adults	Unmarried young adults	Service providers/ Program managers	Local officials
Oneself/respondent's decision	7	-	11	-
Friends	-	9	-	-
Parents/family members	8	8	-	-
Boyfriends/spouse	11	7	-	-
Economic difficulties	7	-	9	11
Movies/media	-	5	6	-
Service providers/health workers	8	-	13	-

These observations are illustrated by the following quotations:

> *I take pills without my husband's knowledge. I make the decision on this matter.* (Married woman, FGD)

I base it on my own situation, and I decide on this. (Married woman, FGD)

I have to ask my husband because I don't want him to blame me later on. (Married woman, FGD)

I tell the client if a method is not good for her. Of course they can make their own decision, but often they listen and take my advice. (Service provider, FGD)

Men talk to other men about STD. They give each other advice on what drugs to take for certain symptoms. (Married man, FGD)

People have to plan their families because times are hard. It is good to have many children, but can you afford it? That is the question. (*Barangay* captain, in-depth interview)

Seminars conducted by health workers also influence our decision [*regarding family planning*]. (Married woman, FGD)

Barangay *health workers and midwives contribute a great deal in my family planning decision making*. (Married woman, FGD)

For several other women, however, the views or advice of their mothers, relatives and friends were important decision-making influences on family planning practice.

> **"**We are forced to practice family planning in order to improve our economic situation.**"**
>
> – A married man, FGD

Married men identified their wives as the family planning decision-makers and mentioned some concern for the health of their wives. Married men said they would not support family planning if it is "not safe" or is harmful to their wives. Men who expressed support for family planning said that they were motivated to use family planning because of their desire for fewer children and to improve family economic conditions. Among health service providers, BSPOs and BHWs say they are aware of their influence on women, and think that they have influenced many of their clients to practice family planning.

In general, married men and local officials do not oppose family planning and reproductive health, but neither group can be relied upon to actively support these programs. With the exception of a few local leaders who oppose family planning and reproductive health programs on religious grounds, local officials as a group are not against family planning and reproductive health. Local officials report that they are likely to support family planning and reproductive health initiatives because they could help alleviate the poor economic conditions of their communities that are aggravated by high birth and population growth rates. A local official said he will support FP to "improve the welfare of his constituents," ease the economic difficulties of families, and reduce social problems in his local government unit.

While the Catholic Church and some local priests, nuns, and religious organizations are clearly perceived as opposing FP and reproductive health, they are not seen as serious threats to reproductive health program activities or important influences on family planning or reproductive health decisions.

Recommendation

It is significant that outreach workers are sources of information with strong influence on women's decision regarding their health. It will be necessary to equip these health workers with skills in information giving, monitoring and counseling.

UTILIZATION OF RFA FINDINGS

One of the major objectives of the rapid field appraisal is to utilize the findings for improving reproductive health policy and programs. An important step that was taken to ensure this was to bring stakeholders to review and discuss the implications of the major findings of the study through a workshop held in Tagaytay City sponsored by the Population Council. The workshop produced the following action plans of the different agencies:

1. Management Sciences for Health (MSH)

The Management Sciences for Health has chosen to address the issue of access and quality of services through their current work with the Matching Grant Program. A set of advocacy activities will be launched to get more LGUs to participate in the program. To address quality of care issues raised involving inadequate infrastructure equipment and poor client provider interaction, the Matching Grant Program's (MGP) will provide technical assistance to DOH's *Sentrong Sigla* (Center of Vitality) in developing quality of care indicators and expanding the certification program of the *Sentrong Sigla* to cover all LGU facilities (such as tertiary level hospitals) beyond the current certification of rural health centers.

The community-based management information system (CBMIS) will be strengthened in the MGP-LGUs. Major reproductive health indicators on maternal and child health along with family planning and nutrition will be regularly monitored and the CBMIS will become a service delivery as well as a management tool. MSH will also help in the expansion of the National Health Insurance Program. In order to respond to the needs of the poor who will continue to be unable to pay for health services, LGUs who wish to participate in the MGP will be required to enroll in the Indigent Program of the Philippine Health Insurance Corporation.

2. Commission on Population (POPCOM)

As the country's policymaking body for population-related matters, POPCOM has sought to revise its policy framework to reflect the paradigm shift called for in international conferences on population. Reproductive health has become a major focus of its program. The weakness of the community's understanding of this concept "has challenged this agency to take a close look at the reproductive health framework and recommended that in their next report to the POPCOM board, dissemination gaps identified in the rapid field appraisal study will be addressed" (RFA Action Plan, Program Management Office, POPCOM, September 2000).

Major areas for action were also identified. Foremost of these are the review of adolescent programs and the identification of best practices for replication or upscaling.

POPCOM will use its existing advocacy programs to advocate for the establishment of adolescent centers by LGUs and other NGOs.

POPCOM will likewise continue to support the contraceptive interdependence initiative (CII) and further study different modes of cost recovery schemes for LGUs.

3. AVSC International

AVSC will extend reproductive health services to men by strengthening the referral system for sterilization, particularly vasectomy, in the MGP areas. In order to address some of the quality of care issues that emerged in the study results, AVSC will train family planning counselors in 158 LGU hospitals and their catchment RHUs. This technical assistance will be extended as well to the private sector such as the Well-family Midwife Clinics, the FriendlyCare affiliates and eight more private hospitals. AVSC will also provide technical to DOH-retained hospitals to increase provision of vasectomy services.

4. Johns Hopkins University / Population Communication Services (JHU/PCS)

A major gap that had been identified by the rapid field appraisal study is the lack of IEC materials and relatively weak community awareness campaigns. JHU/PCS will develop materials and print these in the vernacular so that these can be well understood by the general public. A first theme to address is how to involve men to support reproductive health at the community and household levels.

JHU/PCS will also work with the DOH in developing core messages that are critical for reproductive health awareness, including video materials for the *Sentrong Sigla*. These messages will be provided to local executives to assist them in their advocacy work. Other themes that will be addressed by IEC materials are adolescent issues, sustainability issues, and improving client-provider interaction.

5. The Futures Group (TFG)

The Futures Group will provide POPCOM technical and financial assistance to conduct a reproductive health policy forum to promote awareness of the need for a clear national reproductive health policy. It will also provide DOH technical and financial assistance in the dissemination of the reproductive health policy, and in priority setting of reproductive health services. The Futures Group will give assistance in the conduct of a policy dialogue on adolescent reproductive health needs in response to the findings cited by the study regarding the lack of adolescent services throughout the country. As part of its policy advocacy project, TFG will advocate for increased enrolment of LGUs in the Philippine Health Insurance Corporation Indigency Program.

6. FriendlyCare Foundation, Inc. (FCFI)

The FCFI has chosen to address three major areas: men's low reproductive health awareness, adolescent reproductive health needs, and sustainability of LGU and private sector clinics. To address the first concern, FCFI will expand its RH services to cover men's reproductive health concerns. This expansion will entail the designing and piloting of services that will attract male clients (e.g., smoking cessation program, prostatic examination, services for middle-aged males). Adolescent needs will be addressed through the establishment of youth centers which are distinct from health facilities for the general public and will provide services aimed at promoting healthy lifestyles and avoidance of risky behavior.

On the sustainability of public and private sector clinics, FCFI will support training programs aimed at developing entrepreneurial skills among LGU program managers, as well as other private sector groups. This training will focus on cost-based pricing of services, and clinics that have implemented this will be chosen to serve as preceptor sites.

The utilization of the findings of the rapid field appraisal study was not limited to the CAs' workplans. Subsequent dissemination at the local level resulted in the development of LGU plans for addressing gaps identified in their respective areas. A concrete example of utilization is the announcement of the chairman of the health board

in one city to institutionalize regular public hearings on issues related to reproductive health.

SUMMARY AND CONCLUSIONS

The findings of the RFA in relation to how various groups understand the term "reproductive health" and how they define a reproductive health care program reveal deficiencies which need to be addressed. While the relatively high awareness of STD and HIV/AIDS among men is encouraging, the women's low awareness of these issues is a cause for concern, and hence needs to be corrected by the program. In addition to this, the need to increase the appreciation of local government officials for the issues involved in reproductive health is essential, taking into account the role that they play in determining the availability of health services through the allocation of financial resources.

This low level of reproductive health awareness highlights the need to define and implement a clear national policy on reproductive health. The health policy should reflect the paradigm shift towards client-oriented service delivery as well as include the thrust towards consciousness-raising, adequate information, comprehensive understanding and formation of positive attitudes on the part of the population with respect to reproductive health. Once it is defined, the program must be effectively communicated to LGUs to ensure its implementation.

It is a general perception that the private health system delivers superior service to that of the public health system. The reason for this is the perception that the public health system is hampered by lack of resources, overworked personnel, and patronage practices. Rather than demand additional services, the respondents opt for improved and adequate equipment, facilities, and basic services.

The need to improve quality of care, particularly focusing on better treatment of clients' needs as well as addressing the complaints about patronage practices in the clinics is evident. Because the issues cited are longstanding problems, there is a need for stronger advocacy to pressure national and local government offices to monitor public health facilities. The findings also imply that it may be both unrealistic and unnecessary for local health facilities to provide reproductive health services beyond those currently available, considering their lack of facilities and adequately trained personnel as well as

the fact that the respondents expressed the desire that current services be improved rather than additional ones provided.

Proposal for an Alternative Strategy

For efficiency and cost-effectiveness, the study teams suggest an alternate strategy to distribute RH services across a network of health facilities such as public health centers, higher-level hospitals, youth centers, crises centers, and other specialized clinics. There is clearly no need to impose that all the elements of reproductive health be provided in one agency or facility.

In general, unmarried respondents do not seem particularly interested in reproductive health despite on-going IEC activities focusing on adolescent health and sexuality. The more knowledgeable participants express the need for advice/assistance in dealing with concerns such as avoiding early marriages and pregnancies, STDs, HIV/AIDS, drug addiction, and skin problems. The youth clearly indicate that they prefer to use social and health services in specifically designated youth centers rather than in public or private health care facilities. These findings suggest that adolescents are better served by youth center facilities or existing youth or socio-civic organizations than by the inclusion of adolescent services in regular public health centers. The study teams' recommendation is that the health and population education components of the school curriculum be reviewed to ensure that these components remain relevant and interesting to adolescents. There is a need to evaluate existing youth programs, best practices of the Foundation for Adolescent Development, Inc. and other more successful UNFPA and POPCOM projects to determine ways to improve adolescents' knowledge of reproductive health.

Advocacy activities must be directed to local chief executives and other major stakeholders in order to establish and maintain the operation of adolescent centers. Other suggestions by members of the study team include establishing a program to review and revise training curriculum on counseling; conducting training for youth counselors; to develop core messages and prototype materials for adolescents; developing a common advocacy message on the significance of the adolescent population size reaching reproductive age and their potential contribution to future population growth; and

conducting policy dialogues on adolescent reproductive health needs among policymakers in relevant government agencies and NGOs.

The amount of support and/or opposition existing at local levels for health programs, specifically for family planning and reproductive health care services delivery was also examined, demonstrating that there seemed to be an absence of active opposition to family planning and reproductive health in the areas visited. In spite of this fact, the role of local governments in supporting these programs remains tenuous for reasons that politicians are reluctant to contradict the stand of the church. While health policymakers and program planners must work to increase local government awareness and support for reproductive health care, it is recommended that stronger advocacy by constituents will be necessary to change the nature of local politics and the actions of local officials/politicians.

Clients are generally opposed to the idea of charging fees for services. However, they indicated that they would be willing to pay reasonable fees. It is suggested, therefore, that while the current system of collecting voluntary donations is insufficient to sustain clinic operations, alternative cost recovery schemes may need to be explored by local governments.

Other issues investigated included the identification and evaluation of the adequacy of the sources of family planning and reproductive health care information, as well as the factors that influence family planning decision-making processes. Outreach workers continue to exert an important influence on women's decisions regarding their health. Given that these workers are the true "frontliners" of the program in the community, it is time that their skills in information giving and reproductive health counseling are enhanced.

APPENDIX 1

Participating Partner-agencies

In addition to the Population Council and OPHN-USAID/Manila, participating partner agencies included:

1. AVSC International
2. Commission on Population (POPCOM)
3. De La Salle University (DLSU)
4. Department of Health (DOH)
5. FriendlyCare Foundation, Inc. (FCFI)
6. John Hopkins University / Population Communication Services (JHU/PCS)
7. John Snow Inc. Research and Training Institute (JSI/RTI)
8. Management Sciences for Health (MSH)
9. Program for Appropriate Technology in Health (PATH)
10. Pearl S. Buck International (PSBI)
11. The Futures Group (TFG)

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APPENDIX 2

Methodological Steps Undertaken in the Conduct of the RFA

The research teams spent two to three days to complete the FGDs and key informant interviews in each study area (with different members of the team simultaneously conducting these meetings). Each area team (Luzon, Visayas and Mindanao) had a team leader to facilitate discussions. The following steps were followed in analyzing the data from the FGDs and in-depth interviews:

1. A meeting was held to discuss and analyze the information gathered at the end of the day.
2. The first draft of the area reports (using the notes described above in point 1) was prepared.
3. Each team met to review the first draft and obtain a consensus on the interpretations of the findings.
4. The project coordinator wrote a synthesis report based on the four draft reports from each geographical area which was circulated to the study team members.
5. Based on the suggestions and comments received, the coordinator produced a second draft of the synthesis.
6. PC Manila organized a two-day workshop held September 14-15, 2000 in Tagaytay City for the final review of the synthesis. Each agency's representative drew up a plan for utilizing the findings of the study within the parameters of his/her agency's program. A local dissemination plan was drawn up and local level materials were developed.
7. A dissemination workshop was held in each site to discuss the findings of the study. Local government officials and private sector representatives attended the one-day workshop. The rapid field appraisal team leader assigned in the area presented the results. Participants drew up plans to follow up and address the reproductive health issues and problems identified in their areas.